TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AZALEA ORTHOPEDICS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-1161-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier improperly denied this bill for Dr. Michaels' services on 8/9/16, stating that Dr. Michaels is out of network. Out of network approval good for one year was obtained by the provider on 7/12/16... The carrier has improperly denied the bill again... The submitted documentation shows that the provider made every effort to obtain appropriate payment, to no avail."

Amount in Dispute: $430.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim #] is in the Texas Star Network... Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's and found no evidence Dr. James Michaels is a participant in that Network... Further, Texas Mutual has no evidence the requestor, a non-network provider, received out of network approval to provide the service or treatment. ... Because this fee reimbursement dispute involves a Network requirement under the Insurance Code and not the Labor Code, Texas Mutual argues DWC MDR has no jurisdiction in this matter. No payment due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
August 9, 2016	99204, 99080-73 and G0477	$430.00	$281.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for Work Status Reports.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. Texas Insurance Code §1305 applicable to Health Care Certified Networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A02 – Provider not approved to treat Texas Star Network claimant
   - CAC-243 – Services not authorized by network/primary care providers
   - 225 – The submitted documentation does not support the service being billed
   - 727 – Provider not approved to treat Texas Star Network claimant

Issue(s)

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Did the requestor bill in accordance with 28 Texas Administrative Code §134.203 (b) for HCPCS Code G0477?
3. What is the reimbursement calculation for CPT Code 99080-73?
4. What is the reimbursement calculation for CPT Code 99204?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed for CPT Codes G0477, 99204 and 99080-73 rendered on August 9, 2016 to an injured employee enrolled in the Texas Star Network, a certified healthcare network. The insurance carrier's response indicates that the claim is in the Texas Star Network. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider. The insurance carrier denied/reduced the disputed charges with denial reason code "A02 – Provider not approved to treat Texas Star Network claimant "; "CAC-243 – Services not authorized by network/primary care providers"; "225 – The submitted documentation does not support the service being billed" and "727 – Provider not approved to treat Texas Star Network claimant."

The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

(1) emergency care;
(2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

Review of the "Out of Network Authorization to Treat Injured Worker Covered by the Texas Star Network", dated July 12, 2016, documents that the requestor James Michaels M.D., obtained an out-of-network approval to treat the in-network injured employee. The out of network referral states in pertinent part, "The request to provide necessary medical services for the above injured worker as an out of network provider has been reviewed and approved. This approval is limited specifically to the provider named above and does not extend to other associates or services within a practice group or business entity. The extent of treatment to be provided as the approved out-of-network provider is limited to the referral consultation and/or services not available within the network."

Texas Insurance Code §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

The Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so. The Division finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(3). As a result, the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to Texas Insurance Code §1305.153(c).

2. The requestor billed for HCPCS Code G0477 rendered on August 9, 2016. For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for services in dispute.

   The service in dispute, HCPCS Code G0477 is for clinical laboratory services subject to 28 Texas Administrative Code §134.203 (b) which states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Review of the submitted medical claim finds the health care provider billed for HCPCS Code G0477. The Division finds that reimbursement is recommended pursuant to the National Correct Coding Initiative Manual found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, Chapter 12, Section 12.

   28 Texas Administrative Code §134.203 (e) states in pertinent part, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

   Reimbursement is determined pursuant to Medicare's 2016 Clinical Laboratory Fee Schedule found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/ and calculated as follows:

   Procedure code G0477, service date August 9, 2016, represents a pathology/laboratory service with reimbursement determined per §134.203(e). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.36. 125% of this amount is $14.20.

   As a result, the requestor is entitled to reimbursement in the amount of $14.20 for HCPCS Code G0477.

3. The requestor billed CPT Code 99080-73 rendered on August 9, 2016. For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement.

   Per 28 Texas Administrative Code §129.5 states in pertinent part, "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section..."

   The requestor billed for and submitted documentation to support the billing of the work status report. As a result, the division finds that the requestor is entitled to reimbursement in the amount of $15.00 for CPT Code 99080-73. Therefore, this amount is recommended.

4. The requestor billed CPT Codes 99204 rendered on August 9, 2016. For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for the disputed services.

   28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

The requestor submitted documentation to support the billing of CPT Code 99204, as a result reimbursement is recommended. Procedure code 99204, service date August 9, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.43. The practice expense (PE) RVU of 1.99 multiplied by the PE GPCI of 0.92 is 1.8308. The malpractice RVU of 0.22 multiplied by the malpractice GPCI of 0.822 is 0.18084. The sum of 4.44164 is multiplied by the Division conversion factor of $56.82 for a MAR of $252.37.

The requestor is therefore entitled to reimbursement in the amount of $252.37 for CPT Code 99204.

5. The Division finds that the requestor is entitled to a total recommended amount of $281.57 for the services in dispute. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $281.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $281.57 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.